GROWTH HORMONE FOR AIDS WASTING

PRIOR AUTHORIZATION REQUEST FORM

FAX: (800) 748-0116
Phone: (800) 748-0130

Fax or Mail to
HEALTH INFORMATION DESIGNS

P.O. Box 3210
Auburn, AL 36832-3210

PATIENT INFORMATION

Patient Name: _____ Patient Medicaid #: _____

Patient DOB: _____ Patient phone # with area code: _____

PRESCRIBER INFORMATION

Prescribing physician: _____ License #: _____

Address: _____ Phone # with area code: _____

City/State/Zip: _____ Fax # with area code: _____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.

_____
Physician's signature Date

PHARMACY INFORMATION

Dispensing pharmacy: _____ Provider #: _____

NDC #: _____ J Code: _____ (if applicable) Qty. requested per month: _____

Phone # with area code: _____ Fax # with area code: _____

DRUG/CLINICAL INFORMATION

❒ Initial Request ❒ Renewal (documentation attached to demonstrate effectiveness[1])

Proposed Duration of Therapy: _____ Strength/Quantity: _____ Daily Dose: _____

Height: _____ Weight: _____ BMI: _____

Diagnosis: _____ **ICD-9:** _____

1. Is there documentation of an unintentional weight loss and loss of muscle mass due to AIDS wasting[2]? ❒ Yes ❒ No
2. Is there documentation of a failed trial with appetite stimulants or weight gain agents[3]? ❒ Yes ❒ No
3. Has the patient been on anti-retroviral therapy for the past 120 days? ❒ Yes ❒ No
4. Has the patient been screened for intracranial malignancy or tumor? ❒ Yes ❒ No
5. If a history of malignancy exists, has the patient been free of recurrence for at least the past 6 months?
   ❒ Yes ❒ No ❒ No malignancy

If any of the above is answered NO, request will be denied.

6. Does the patient have any of the following contraindications? Check all that apply.
   - ❒ Proliferative or preproliferative diabetic retinopathy
   - ❒ Pseudotumor cerebri or benign intracranial hypertension
   - ❒ Pregnancy

If any of the above contraindications apply, the request will be denied.

[1] Weight stabilization or weight gain must be reported to continue therapy.

[2] There must be an unintentional weight loss of 10% over 12 months or 7.5% over 6 months or BMI < 20 kg/m^2.

[3] Drugs to stimulate appetite and/or promote weight gain, such as Periactin®, Marinol®, Megace®, Oxandrin®, or androgenic steroids.

FOR HID USE ONLY

❒ Approve request ❒ Deny request ❒ Modify request ❒ Medicaid eligibility verified

Comments: _____

_____ _____
Reviewer's Signature Response Date/Hour